

EXHIBIT A



Western
Neurological
Associates, P.C.

01/12/2016

Ms. Lisa Marcy

Clyde Snow
Attorneys at law
One Utah Center
13th floor
201 S. Main St.
Salt Lake City, Utah
84111

Dear Ms. Marcy,

I am writing concerning the above-named patient, Mr. Joshua Chatwin.

I am providing to you a medical opinions concerning the patient and injuries received on 5/28/10.

I will answer your questions to the best degree of my medical certainty; I will repeat your question:

1. Question: "Whether you believe that Mr. Chatwin suffered injuries based upon being thrown to the cement by the officer, which may result in future damages." It is my opinion that Mr. Chaplin suffered injuries after being thrown to the cement. This will result in future damages.

2. Question: "What are those damages" His damages are:

a. The patient suffered traumatic brain injury with left epidural hematoma, pneumocephalus, likely brain edema, and skull fracture. This opinion is based on his imaging done at the hospital, with CT brain showing those injuries.

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b. Left cranial nerve VIII damage producing left sensorineural hearing loss, and subjective decreased hearing and tinnitus. This opinion is based on his audiometric examination showing decreased high frequency hearing on the left, his symptoms and his physical examination.

c. Worsening posttraumatic migraine. The patient has a history of migraine with aura prior to his injury. Since his traumatic brain injury he has had worsening migraine with aura. This opinion is based on his history. I consider him a reliable historian.

d. Left shoulder acromial clavicular separation. This opinion is based on x-rays performed at the hospital. He is continuing to have left shoulder pain.

e. He complains of depression. This is based on his history. Again, I consider him a reliable historian.

3. Question: "Whether the tinnitus in Mr. Chatwin's ear was caused by the incident". It is my opinion that his tinnitus is caused by the injury, as above.

4. Question : "The possibility of violent behavior resulting from the effect of head trauma." It is my opinion that Mr. Chatwin's head injury itself may have contributed to his "violent" behavior, assuming that occurred. Depending on a patient's degree of head injury and underlying degree of confusion and disorientation, it would not be unexpected for a patient to become "combative" or "violent". This is well known by neurological providers that patients who have suffered head injury, seizures, and other neurological trauma, may need to be restrained, sedated, or otherwise dealt with.

5. Question: "The effects of alcohol and balance, posture and coordination." The patient's blood alcohol level was extremely high at 0.319. At this level, alcohol would significantly impair his cognition, coordination, dexterity, speech, and balance. At levels greater than 0.25 there is a risk of asphyxiation and choking, at levels greater than 0.30 stuporous possible, and at levels of greater than 0.35, coma may be present.

6. Question: "The amount of force required to cause Mr. Chatwin's shoulder injury." It is my opinion that a significant amount of force would have been required to produce a shoulder injury. It is my opinion that at such an elevated blood alcohol level, simply collapsed to the ground would not have produced a shoulder injury.

7. Question: "What medical assistance, if any, should have been applied to an unconscious individual who is head had struck the cement?" An unconscious individual with a significant head injury should have required immediate medical attention with activation of 911. He should have been handled very carefully due to the possibility of cervical spine instability from cervical injury occurring at the time of the head trauma. If at all possible he should have been placed horizontally, kept warm, while waiting for

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paramedics. If had a seizure had occurred, prevention of aspiration would have been necessary. Even simply checking the pulse would have been reasonable. Obviously, fortunately, no CPR intervention was needed.

In understanding the patient's injuries, I would offer the additional opinions concerning the patient's future:

1. I consider the patient to be at risk for future posttraumatic epilepsy. He suffered significant head injury, with fracture, bleeding. Residual blood products are imaged on MRI (reports enclosed). It is well known that hemosiderin is epileptogenic. Should the patient develop that condition, future medical expenses would include physician visits, imaging, EEGs and medication. This will be especially problematic for the patient in view of his history of alcohol dependence. He will need to be especially vigilant to remain alcohol free. There is no now way to prevent posttraumatic epilepsy from occurring.
2. The patient is also having posttraumatic migraines, migraine with aura. This may require specific anti- migraine treatment with antimigraine medication and physician visits in the future.
3. I do not expect his hearing to improve.
4. He will need to avoid future head injuries. The neurological community considers head injuries to be cumulative. He has a young individual. He will need to be certain that in the future he takes measures to wear a helmet. At would be my recommendation that he avoid any sports or activities that put him at risk for recurrent head injury
5. Review review of the patient's MRI by radiology indicates that the skull fracture remains mildly depressed. This is of continuing concern. The patient will require a CT of the brain to further continuing evaluate bony abnormality from his skull fracture. I anticipate recommending neurosurgical consultation. From that evaluation, additional medical expenses may be incurred.

Concerning my opinions and testimony:

1. My opinions are to a reasonable degree of medical certainty and a reasonable degree of probability.
2. My opinions are based upon the knowledge gained from my expertise accumulated in my 44 years of medical practice as a physician and 37 years as a board-certified neurologist.
3. My opinions are also based upon my examination of the medical records listed in this report:

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-Intermountain Medical Center records from the patient's inpatient stay at Intermountain Medical Center from 5/18/10 to 5/20/10,

-My reading and interpretation of the CT scans of the brain from Intermountain Medical Center from 5/18/10 referenced in my report,

-EEG performed 1/11/16,

-MRI of the brain with and without contrast performed 1/11/16,

-MRA of the intracranial arteries and extracranial arteries from 1/11/16,

-Contrast-enhanced MR venogram from 1/11/16,

I also reviewed on the results of the Ear Nose and Throat physician and that evaluation on 611 with audiogram, and that physicians impairment rating from 1/13/13.

4. I reviewed and relied upon my report of the patient's neurological consultation, medical record #254830. His consultation was at Western neurological Associates, PC. I also reviewed Ms. Lisa Marcy's letter of 1/7/16, but relied upon my own interview of the patient.

5. The facts and data upon which I base my opinions are the medical information reference in this report, my interview and examination of Mr. Chatwin, the medical records and test results reviewed and my examination of the patient.

6. The reasons for my opinion are set out in my report and are based upon the medical records reviewed, my examination of Mr. Chatwin, and the tests I ordered.

7. My methodology is a standard methodology used by physicians in my field of specialization, has been subjected to peer review for many years, minimizes errors, and is the method generally accepted by experts in my field for evaluating and rendering a medical opinion for patients with Mr. Chatwin's medical and social history.

8. I may use visual aids as part of my testimony. X-ray, CT, MRI results and medical records may be used as exhibits. If necessary, I may use illustrations and models of human anatomy such as illustrations of the human skull, brain, inner ear and skeleton. I will use my own medical records in my testimony. I may use the photos of Mr. Chatwin taken on the night of his arrest as part of my testimony. I may also use a summary chart my medical findings.

I have included my curriculum vitae.

I have not testified in court as an expert or at trial or deposition within the last 4 years. My CV includes 2 publications within the last 10 years. My fee for study and testimony at depositions and

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trial is \$500 an hour.

Regards,



Walter H. Reichert, M.D.

WESTERN NEUROLOGICAL ASSOCIATES, P.C.
WALTER H REICHERT, MD
1151 EAST 3900 SOUTH B150
SALT LAKE CITY, UT 84124-1296
801-262-3441

Patient# 254830
Patient Name: JOSHUA CHATWIN
Patient DOB: 01/29/1982
Date: 01/06/2016

INITIAL OFFICE NEUROLOGICAL CONSULTATION

Transition of care: No

CHIEF COMPLAINT: Traumatic brain injury

HISTORY OF PRESENT ILLNESS: Mr. Chatwin is a 33-year-old male.

The patient's injuries occurred on 5/18/2010. At this time the patient reports to me that he was refused service at the Draper liquor store. When he drove home, he was met in the driveway of his parents home by police authorities. He was arrested. He was handcuffed with his hands behind his back. He was turned and put face forward against his truck.

He reports to me that he has no memory of events beyond that. The next thing he can remember is awakening in the IMC intensive care unit, intubated, about 12 hours or so later.

He was told that a Draper police officer spun him about and to the ground, such that he struck his head on the left on a cement curb.

He was taken to Intermountain Medical Center. Records from that facility indicate that he was agitated and uncooperative. He had ecchymoses around his head on the left and pinna of left ear and blood draining from his left external ear canal with left hemotympanum. In order to obtain appropriate imaging he was sedated and intubated and chemically paralyzed.

CT scan of the brain in summary showed a left epidural hematoma, left skull fractures, left pneumocephalus. CT scan of cervical spine was negative for fracture. He was admitted. Blood alcohol level 319.

He was seen in neurosurgical consultation by Dr. Joel McDonald. He was observed. No surgery.

A CT scan was repeated the day following admission. Epidural hematoma and pneumocephalus improved, see comments below.

He was discharged on 5/20/10 to home without medical followup.

The patient reports to me that he has had no medical care since his discharge from the hospital. He has had no followup imaging since his last CT scan in the hospital on 5/18/10.

His continuing problems from that injury are as follows:

1. Constant tinnitus in his left ear.

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2. Decreased hearing in his left ear.
3. Mild left shoulder pain mainly with activity. He suffered a left shoulder grade 1 separation of the acromioclavicular joint.
4. Increasing headaches. He has a history of migraine with aura, with headaches occurring infrequently prior to his accident, perhaps once or twice a year. Headaches have increased in frequency since the injury. He is now having headaches occurring twice monthly, where in twice a month he will have 2 sets of 3 headaches in a row all associated with migrainous auras description below.
5. He has had some depression since the accident.

He denies seizures, loss of consciousness, weakness, loss of sensation, difficulty with speech, difficulty with memory, and neck pain.

Patient is a recovering alcoholic, and he reports that he has been dry 70 days. He is currently in a treatment program.

His history of migraine with aura: His headaches begin with a small black spot in his visual field paracentrally to the right of center with a border of faint colors. This "spot" then grows to cover about 80% of his visual field and will block his vision. That visual symptom lasts about 30 min. and he will then develop a severe headache that will last 24 hours. He has taken Excedrin, but that really doesn't help. There is no family history of migraine.

REVIEW OF SYSTEMS

General: Negative for weight change, fatigue, fever, chills, difficulty with activities of daily living and difficulty sleeping.

HEENT: Positive for tinnitus and hearing loss.

Cardiovascular: Positive for intermittent hypertension mainly when drinking heavily.

Respiratory: Negative for shortness of breath with activity, shortness of breath at rest, cough, asthma and snoring.

Musculoskeletal: Negative for weakness, loss of muscle mass, joint pain, neck pain and low-back pain.

Gastrointestinal: Negative for changes in appetite, nausea, vomiting, diarrhea, constipation, dysphagia and hematochezia.

Neurologic: Positive for headaches.

Psychiatric: Positive for depression.

Genitourinary: Negative for incontinence, dysuria and history of nephrolithiasis.

Dermatological: Negative for rash and hair loss.

Hematological: Negative for anemia, easy bruising and bleeding disorder.

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Endocrine: Negative thyroid dysfunction and diabetes.

PAST MEDICAL HISTORY

ALLERGIES: NKDA

MEDICATIONS:

FAMILY HISTORY: Family history is negative for migraine. Family history is positive for hypertension.

SOCIAL HISTORY: Patient was born in Del Rio, Texas. He is single without children. He is currently unemployed.

PHYSICAL EXAM

Vitals: Wt:205 (93.18kg) Ht:74 BMI:26.3 BP:125/85 Resp:UNLABORED Pulse:68

General: healthy-appearing 32-year-old male in no acute distress.

Head and Neck: Tympanic membranes and external auditory canals are clear, no evidence of otorrhea or rhinorrhea.

Musculoskeletal: No joint deformities.

Cardiovascular: pulse is regular.

NEUROLOGIC EXAM

Mental status: Alert and oriented x3 and cooperative. Speech is clear. Mood and affect are appropriate. No deficits to memory, language, or fund of knowledge found with testing.

Cranial nerves: II - Visual fields are full to finger confrontation. Discs are flat. No O.A. III, IV & VI - PERRLA. EOMs are full without diplopia or nystagmus. No APD. V - Facial sensation normal. VII - No facial weakness. VIII - Hearing is decreased on the left to finger rub and tuning fork. Weber lateralizes to the right. Romberg positive bilaterally. IX - Voice tone normal. X - Palate rises midline. Uvula is midline. XI - Shoulders shrugs normal. XII - Tongue protrudes midline without atrophy or fasciculation.

Motor: Strength is symmetrical bilaterally in the upper and lower extremities. Good muscle bulk, tone, and coordination.

Sensory: Intact to primary and secondary modalities.

Cerebellar: No ataxia.

Reflexes: 2+ equally symmetrical in upper and lower extremities. Toes are bilaterally downgoing.

Gait/station: Normal including tandem walk and Romberg.

IMAGES AND STUDIES: 1. A noncontrast CT scan of the brain from 5/18/10 shows a comminuted and minimally depressed left skull fracture in parietal and temporal bones, and left mastoid skull fracture. Left temporal epidural hemorrhage.

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Pneumocephalus in left parietal and temporal regions. There is effacement of the gyral and sulcal markings over the left hemisphere, suggesting edema. No shift. Layering of fluid in sinuses.

2. Noncontrast CT of brain also dated 5/18/10 shows resolution of extra-axial temporal hemorrhage, but again shows the fractures. Fluid in left mastoid air cells as well as in sphenoid sinus. Again noted is loss of normal gyral and sulcal markings over much of the left hemisphere. No shift.

3. CT scan of cervical spine from 5/18/10 shows no fracture.

IMPRESSION: 32-year-old male with traumatic brain injury 5/18/10.

1. Left temporal skull fractures, mastoid fracture.

2. Left epidural hematoma.

3. CT imaging to my eye suggests left hemisphere edema at time of his acute brain injury. CT showed left hemisphere pneumocephalus that had resolved by his second CT.

4. Sensorineural left hearing loss, with symptomatically decreased hearing in left ear and left tinnitus.

5. Worsening of migraine with aura. Posttraumatic migraine with aura.

6. Mild left shoulder pain as residual to separation of left acromioclavicular joint. Pain with activity.

7. He reports mild depression.

Diagnosis 1: 794.09 abnormal brain MRI scan; 346.01 Migraine, classical w/ intrac; 389.9 Hearing loss, NOS; 388.32 Tinnitus;

PLAN 1: Imaging to further evaluate the sequela of the patient's head injury and head trauma, evaluate for injury to dural sinuses, evaluate for posttraumatic aneurysm, injury to arterial vessels including dissection, evaluate for any evidence of posttraumatic epilepsy:

-MRI of brain with gadolinium

-MRV

-MRA x2

-EEG.

PLAN 2: We discussed treatment of his increasing migraine with aura. At this time we will start sumatriptan 100 mg tablets: He will take one at the onset of a migraine, may repeat in 2 hours if needed. Maximum 2 doses per day. He will try half a tablet, repeat if necessary. He will also try Aleve with first dose of sumatriptan. If his headaches worse and he may need to be placed on a migraine preventative. Because of his history of alcohol abuse, we will need to be careful to avoid any potentially addicting medications. I have also

254830 JOSHUA CHATWIN 01/06/2016

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suggested that he may try effervescent aspirin along with caffeine for severe headache. I also discussed with him the concept of rebound headache and medication overuse headaches, and that he should avoid excessive painkillers of any sort, including over the counters, should his headaches worsen.

PLAN 3: He will be calling for test results. Plans pending those results.

ORDERS: 70547 MRA: neck\ 70544 MRA : intracranial\ 70553 MRI Brain with and without gad and GRE\ 70545 MRV GAD\; 95819 EEG: regular\

Total time spent with patient: 60 min., of which greater than 50% of the time spent discussing traumatic brain injury, reviewing imaging, discussing migraine, discussing treatment alternatives, counseling and coordination of care.

This visit was dictated with voice recognition software, therefore there may be errors.

(Electronically Signed)

WALTER H REICHERT MD

WHR/

WESTERN NEUROLOGICAL ASSOCIATES, PC
Diagnostic Imaging Center
1187 East 3900 South, Salt Lake City, UT 84124
801-263-1886

PATIENT NAME: JOSHUA CHATWIN

MRN#: 254830
DOB: 1/29/1982
GENDER: Male

ORDERING PROVIDER: WALTER H REICHERT, MD

CONSULTING PROVIDER:

Addendum at the
end of this report

Study Date/Time:	Accession #:	Procedure Description:
1/11/2016 7:20 AM	177506	MR BRAIN WO/W GAD MRA COW MRV WITH
GAD MRA NECK		

CLINICAL HISTORY: Male of 33 years of age, who is referred for evaluation of headache, visual symptoms, worsening migraines with aura. Patient has a past history of a small left epidural hematoma in association with left parietal/temporal bone fractures on preceding head CT of 5/18/2010.

COMPARISON: Head CT 5/18/2010.

BRAIN MRI SCAN WITHOUT AND WITH CONTRAST

PROCEDURE: The patient's brain was scanned today on the Philips Gyroscan Achieva 1.5 Tesla magnet, with the following acquisitions:

1. Sagittal 5 mm FLAIR.
2. Axial 5 mm T1, FLAIR, T2* FFE and T2.
3. Axial 5 mm diffusion-weighted (DWI) sequence with ADC map.
4. Coronal 3 mm T2 turbo spin-echo (TSE).
5. Axial 5 mm post-contrast T1.

CONTRAST DOSAGE: 20 cc mL IV gadolinium (MultiHance).

FINDINGS: The T2 FLAIR sagittal images demonstrate the pituitary, pons and midbrain, upper cervical cord, medulla, and cerebellar vermis and fourth ventricle to be normal and the tonsils end at the foramen magnum. The other midline structures appear normal. Scans through the hemispheres demonstrate no abnormal signals in the deep white matter or cortex.

Axial images through the posterior fossa demonstrate the CP angle cisterns and internal auditory canals, fourth ventricle, cerebellar hemispheres, pons and midbrain to be normal. The third ventricle is of normal width and lies midline with normal basal ganglia. The lateral ventricles are symmetrical and of normal size for patient age 33. No diffusion restriction is seen.

PATIENT NAME: JOSHUA CHATWIN

MRN#: 254830
DOB: 1/29/1982
GENDER: Male
STUDY DATE/TIME: 1/11/2016 7:20 AM



Gradient echo sequences especially the axial gradient echo sequence demonstrates a tiny area of old hemorrhage along the periphery of the superior aspect of the lateral portion of the left parietal lobe. This finding measures 0.6 cm x 0.4 cm. There is no corresponding defect in the parenchyma in this area on other sequences. This finding is in the exact location where patient had a tiny acute hemorrhage on CT exam of 5/18/2010. Present finding correlates in size and location to the finding on the prior CT exam. The lack of a parenchymal abnormality in the area on all the other sequences including the contrast-enhanced study suggests that the finding may be extra-axial rather than in the parenchyma. The adjacent inner table of the left parietal bone shows some mild irregularity related to the old fracture in this area. The vascular flow-voids appear normal. The postcontrast scans demonstrate no areas of abnormal enhancement in the brain.

Minor mucosal thickening or a small amount of fluid is detected in the left ethmoidal sinus and in the right maxillary sinus.

IMPRESSION:

1. Tiny area of old hemorrhage measuring 0.4 cm x 0.6 cm is noted along the periphery of the left superior lateral parietal lobe. This finding is in the exact location of patient's acute hemorrhage on 5/18/2010. Findings suggest that this small area of old hemorrhage is in the extra-axial tissues rather than in the parenchyma as discussed above.
2. Healed old fracture of the adjacent left parietal/temporal bone.
3. Minor air fluid level or mucosal thickening is noted in the left ethmoidal and right maxillary sinuses.

CLINICAL HISTORY: Male of 33 years of age, who is referred for evaluation of headache visual symptoms and worsening migraine with aura. Patient had an old head injury on 5/18/2010 with small epidural hematoma and parietal temporal /skull fracture

COMPARISON: Head CT of 5/18/2010.

MRA OF THE INTRACRANIAL ARTERIES WITHOUT CONTRAST

PROCEDURE: Utilizing the Philips Gyroscan Achieva 16-channel, 1.5 Tesla magnet, the following pulse sequences were obtained: MR angiography evaluation of the intracranial arteries was performed with 1mm 3D FFE inflow (TOF) angiography and raw-data derived Maximum Intensity Projections (MIPs).

CEREBRAL MRA FINDINGS: The internal carotid arteries pass through their siphons to their bifurcations into normal A1 and M1 segments. The basilar artery is smooth up to its bifurcation into posterior cerebral arteries. No vascular malformations, vascular disease, or aneurysms are demonstrated.

IMPRESSION:

1. The MR angiogram evaluating the intracranial great vessels through the circle of Willis is within normal limits.

PATIENT NAME: JOSHUA CHATWIN

MRN#: 234830
DOB: 1-29-1982
GENDER: Male
STUDY DATE TIME: 1-11-2016 7:20 AM

MRA OF THE NECK ARTERIES WITHOUT CONTRAST

PROCEDURE: Utilizing the Philips Gyroscan Achieva, 1.5 Tesla magnet, the following pulse sequences were obtained: MR angiography evaluation of the neck arteries was performed with 3 mm 2D FFE (TOF) inflow angiography and raw-data derived Maximum Intensity Projections (MIPs).

NECK MRA FINDINGS: The common carotid arteries bilaterally are smooth and normal through their bifurcations into normal internal and external carotid arteries. The vertebral arteries are smooth and unremarkable in the neck. Normal asymmetry is detected in the vertebral arteries. The right vertebral artery is slightly smaller than the left.

IMPRESSION:

1. MR angiogram evaluating the great vessels in the neck is within normal limits.

CLINICAL HISTORY: Male of 33 years of age, who is referred for evaluation of headache, visual disturbance, and worsening migraines with aura. Patient has a past history of old trauma with a small left epidural hematoma and left parietal/temporal bone fractures.

COMPARISON: Head CT of 5/18/2010.

CONTRAST ENHANCED CEREBRAL MR VENOGRAPHY

PROCEDURE: 2 x 1 mm post contrast-enhanced sagittal cerebral MR venography was performed on the Philips Gyroscan Achieva 1.5 Tesla magnet, with maximum intensity projections (MIPs) derived from the raw-data.

CONTRAST DOSAGE: 20 cc mL IV gadolinium (MultiHance).

FINDINGS: The superior sagittal sinus, internal cerebral veins, vein of Galen, straight sinus, torcular, transverse and sigmoid sinuses and internal jugular veins are normal in overall course and caliber. The transverse sinus shows normal asymmetry. The left transverse sinus's width is less than the right. There is no evidence of venous thrombosis.

IMPRESSION: Normal contrast enhanced (CE) cerebral MRV findings.

Addended on 1/13/2016 8:14 AM by Steven Edelman.

A second review of patient's head MRI was done today. Upon this review an old mildly depressed left parietal bone skull fracture is once again seen especially on the axial FLAIR, axial contrast-enhanced, and the coronal T2-weighted sequences. This old minimally depressed left parietal bone skull fracture is producing a minimal focal 0.6 cm extra-axial indentation on the adjacent left parietal lobe. In this same location on the axial T2 FFE sequence is seen a minute extra-axial hemosiderin deposit related to patient's old tiny epidural hematoma in this region. The underlying parenchyma shows no signal abnormality. No edema or gliosis is seen.

PATIENT NAME: JOSHUA CHATWIN

MIRN#: 254830
DOD: 1/29/1982
GENDER: Male
STUDY DATE TIME: 1/11/2016 7:20 AM

Dictated by: Steven Edelman
Dictated on: 1/11/2016 7:38 AM
Signed by: Steven Edelman 1/11/2016 10:18 AM

PATIENT NAME: JOSHUA CHATYVIN

MRN: 254830
DOB: 1/29/1982
GENDER: Male
STUDY DATE/TIME: 1/11/2016 7:30 AM

WESTERN NEUROLOGICAL ASSOCIATES, P.C.
WALTER H REICHERT, MD
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801-262-3441

Patient# 254830
Patient Name: JOSHUA CHATWIN
Patient DOB: 01/29/1982
Date: 01/11/2016

ELECTROENCEPHALOGRAPH REPORT

Referring Physician: Dr. Reichert
EEG NO: 16-007
AGE: 33
TECH: Don

HISTORY: 33-year-old male with history of left temporal skull fracture and hematoma.

TECHNIQUE: Routine EEG. The International 10-20 system of electrode placement is used with scalp-to-scalp and scalp-to-ear recording on 18 channels for 30 minutes with disc electrodes. The tracing is technically satisfactory. The patient is in the, drowsy, and sleep states. Photoc stimulation and hyperventilation are performed.

MEDICATIONS: None.

DESCRIPTION: Resting background is well-organized and consists of low-voltage fast activity beta with a frontal predominance of moderate amplitude well modulated approximately 10 Hz alpha rhythms posteriorly. During drowsiness there is alpha attenuation and low amplitude 4-6 Hz synchronous theta slowing. During sleep there are vertex potentials, sleep spindles, and K complexes. No focal or paroxysmal features present.

Photoc stimulation shows photoc driving without abnormalities.

Hyperventilation alerts the background.

IMPRESSION: Normal EEG.

Electronically signed by Walter H. Reichert, M.D.

CURRICULUM VITAE
WALTER H. REICHERT, M.D.
1151 East 3900 South, #B150
Salt Lake City, Utah 84124

N

CURRENT POSITION:	Vice-President, Western Neurological Associates, PC General Neurologist, July, 1982 to present
BORN:	June 19, 1946 - Salt Lake City, Utah
COLLEGE: 1964 - 1968	University of Utah, Salt Lake City, Utah BS degree (Zoology & Entomology)
MEDICAL SCHOOL: 1968 - 1972	University of Utah School of Medicine
RESEARCH ASSIST: Summer 1969 and 1970	Department of Physiology University of Utah
INTERNSHIP: 1972 - 1973	Washington University Barnes Hospital St. Louis, Missouri
RESEARCH ASSOC: 1973 - 1975	National Institute of Health Bethesda, Maryland
NEUROLOGY RESIDENT: 1975 - 1978	Cornell University New York Hospital New York City, New York
NEUROLOGY FELLOW: 1978 - 1979	Memorial Sloan-Kettering Cancer Center New York City, New York
CHIEF RESIDENT NEUROLOGY: 1978	Cornell Medical School New York Hospital New York City, New York
CLIN. ASSIST. PROF. NEUROLOGY: 1979 - 1982	Cornell Medical School New York City, New York
ATTENDING	Head of Neurology

NEUROLOGIST: Neuro-Trauma Unit
1979 - 1982 The Burke Rehabilitation Center
White Plains, New York

BOARD CERTIFIED: American Board of Psychiatry and Neurology (Neurology)
1979

DIPLOMA: National Board of Medical Examiners

HONORS: Magna cum laude; Phi Kappa Phi
Alpha Omega Alpha
Paul Wintrobe Memorial Award (Outstanding senior student)
Honors in Medicine, Research Award
Clinical Clerk, National Hospital, Queen Square
Guest Neurology Examiner, Oral Examination of American
Board of Neurosurgery (September 23-26, 1986)

SOCIETIES: American Academy of Neurology
Utah Medical Association
Salt Lake Medical Society

PUBLICATIONS: A Round and Amoeboid Microglial Cells in Neonatal Rabbit
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